The Commonwealth of Massachusetts
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street
Boston, MA 02108
(617) 973-0971
www.mass.gov/dph/dentalboard

INITIAL DENTAL LICENSURE BY EXAMINATION

(As required pursuant to 234 CMR 4.00)

The Board of Registration in Dentistry (Board) may grant a license by to a dentist by examination, provided the applicant is of good moral character, has met all of the eligibility requirements, and has submitted the following documentation and information:

- An accurate, complete, signed and notarized application.
- Payment of the non-refundable and non-transferable licensing fee.
- An original transcript with the college seal indicating the degree granted and the date of graduation from a CODA-accredited dental school or an official letter including the college's seal which is signed by the appropriate authority and attests to the applicant's degree and date of graduation.
- A written statement that is the result of a physical examination, conducted within one year of the date of application, attesting to the health of the applicant and to any impairments which may affect the ability of the applicant to practice dentistry.
- Documentation of a passing score on each of the following exams:
  (a) Parts I and II of the American Dental Association National Board Examination;
  (b) The CDCA or other state or regional examination approved by the Board; and
  (c) Massachusetts Dental Ethics and Jurisprudence Examination, please email the Board at dentistry.admin@state.ma.us to request a copy.
- Proof of current certification in American Red Cross Cardiopulmonary Resuscitation/Automated External Defibrillation for the Professional Rescuer (CPR/AED), or the American Heart Assoc. Basic Life Support for Healthcare Providers (BLS), or ACLS/PALS.
- A color photograph (passport-sized or larger).
- A statement disclosing any disciplinary action, civil, and/or criminal action taken against the applicant at any time prior to the date of application, with supporting documentation as may be required by the Board.
- Proof satisfactory to the Board of good moral character. Provide signatures from two (2) licensed dentists (who do not need to be licensed in Massachusetts) familiar with the character and quality of the applicant. Immediate family members or close relatives do not qualify.

Please Note:

- Incomplete applications will delay licensure processing.
- Please retain a copy of all application documents for your records.
- Confirmation of your license status will be available under "Check a License" on our website www.mass.gov/dph/dentalboard as soon as your licensure application is approved.

GENERAL INFORMATION

HOW TO OBTAIN PRESCRIPTION WRITING PRIVILEGES

A Massachusetts Controlled Substance Registration (MCSR) is required before a federal (DEA) Controlled Substance Registration will be issued.

Massachusetts Department of Public Health
Drug Control Program
Phone: (617) 973-0949
Email: dcp.dph@state.ma.us
State information and registration application forms may be obtained at :
www.mass.gov/dph/dcp

U.S. Department of Justice
Drug Enforcement Agency
(617) 557-2100
1-800-882-9539
Federal information and registration application forms may be obtained at:
www.deadiversion.usdoj.gov

HOW TO REGISTER RADIATION EQUIPMENT

Massachusetts Department of Public Health
Radiation Control Program
Phone: (617) 242-3035
Fax: (617) 242-3457
State registration information and registration application forms are available at:
www.mass.gov/dph/rcp

HOW TO FORM A CORPORATION OR APPLY FOR A CLINIC LICENSE

To form a corporation for a dental practice that is solely owned by licensed dentists, please contact the Massachusetts Secretary of State's office at (617) 727-2828 to request the form "Certificate by Regulatory Board." Submit the completed form (by mail or in person) and appropriate fee to the Board for processing. A check or money order payable to the Commonwealth of Massachusetts for $30 for each dentist listed on the form is required. If the practice is owned by non-dentists, you must apply for a clinic license by contacting the Massachusetts Division of Health Care Quality at (617) 753-8000 or www.mass.gov/dph/dhcq

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BOARD USE ONLY
Receipt #_____

Fee :_____

Jurisprudence: Pass _____ Fail _____

APPLICATION FOR INITIAL DENTAL LICENSURE BY EXAMINATION

1. APPLICANT NAME: _____
(Last) (First) (Middle)

2. MAIDEN NAME/OTHER NAME: _____

3. ADDRESS OF RECORD: _____
(Street) (Apt #)

_____
(City) (State and/or Country) (Zip Code)

Please Note: Your address of record may be a home or business address and is considered public information.

4. MOST RECENT PREVIOUS ADDRESS: _____

5. TELEPHONE NUMBER(S): Day: _____ Cell: _____

6. EMAIL ADDRESS: _____

7. _____/_____/_____ _____ _____ EYE COLOR: _____
Date of Birth (mm/dd/yyyy) Place of Birth (city/state/country)

HEIGHT: ____ Feet ____ Inches WEIGHT: ____ Lbs. MOTHER'S MAIDEN NAME: _____

8. SOCIAL SECURITY NUMBER (SSN) (**disclosure is mandatory**): _____/_____/_____
Pursuant to M.G.L. c. 62C, s. 47A, the Bureau of Health Professions Licensure is required to obtain your SSN and forward it to the Massachusetts Department of Revenue (DOR). The DOR will use your SSN to ascertain whether or not you are in compliance with all Massachusetts tax laws pursuant to M.G.L. c. 62C, s. 47A and child support laws pursuant to M.G.L. c. 119A, s.16.

EDUCATION

9. GRADUATE OF: _____
Name of CODA-Accredited Dental School

_____
City State Zip Code

10. DATE OF GRADUATION FROM A CODA-ACCREDITED DENTAL SCHOOL DATE _____
MM/DD/YYYY

DEGREE _____
DMD/DDS

AN OFFICIAL TRANSCRIPT OR ORIGINAL LETTER FROM THE DEAN'S OR REGISTRAR'S OFFICE CONFIRMING THE ABOVE INFORMATION MUST BE INCLUDED.

11. NATIONAL BOARD CERTIFICATION PART I/PART II/INTEGRATED: DATE(S) COMPLETED

_____

12. REGIONAL OR STATE BOARD EXAMINATION - A COPY OF PASSING SCORES ON EACH SECTION OF A CLINICAL COMPETENCY EXAMINATION OTHER THAN CDCA MUST BE INCLUDED WITH THE APPLICATION. PLEASE REFER TO THE BOARD'S WEBSITE AT WWW.MASS.GOV/DPH/DENTALBOARD FOR INFORMATION ON BOARD-APPROVED EXAMINATIONS.

CHECK HERE IF YOU HAVE TAKEN THE CDCA ☐ DATE OF EXAM _____
MM/DD/YYYY

OTHER EXAMINATION _____ DATE OF EXAM _____
MM/DD/YYYY

VERIFICATION OF OTHER LICENSES/BOARD REGISTRATIONS

13. LIST BELOW ALL PROFESSIONAL LICENSES OR REGISTRATIONS INCLUDING PROFESSIONS OTHER THAN DENTISTRY WHETHER OR NOT YOU HAVE PRACTICED UNDER THAT LICENSE OR REGISTRATION.

NOTE: Applicants must obtain official verification of each professional license or registration from each state or jurisdiction and submit it with this application.

☐ **I DO NOT CURRENTLY HOLD AND HAVE NEVER HELD A PROFESSIONAL LICENSE OR REGISTRATION IN ANY OTHER STATE OR JURISDICTION.**

☐ **I CURRENTLY HOLD A PROFESSIONAL LICENSE OR REGISTRATION AS FOLLOWS:**

Issuing Jurisdiction	Profession	License/Certification Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

GOOD MORAL CHARACTER QUESTIONS

IF YOU ANSWER "YES" TO ANY OF THE FOLLOWING QUESTIONS, PLEASE ATTACH A SEPARATE SHEET EXPLAINING THE CIRCUMSTANCES AND PROVIDE ALL RELEVANT DOCUMENTATION INCLUDING THE FINAL DISPOSITION OF ANY CRIMINAL CHARGES OR DISCIPLINARY ACTION BY ANOTHER LICENSING BOARD AND COMPLETE PAGES 6 AND 7 OF THIS APPLICATION.

NOTE: An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' with respect to an inquiry herein relative to prior arrests, criminal court appearances or convictions. An applicant for employment or for housing or an occupational or professional license with a sealed record on file with the commissioner of probation may answer 'no record' to an inquiry herein relative to prior arrests or criminal court appearances. In addition, any applicant for employment or for housing or an occupational or professional license may answer 'no record' with respect to any inquiry relative to prior arrests, court appearances and adjudications in all cases of delinquency or as a child in need of services which did not result in a complaint transferred to the superior court for criminal prosecution.

14. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

15. Has any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction taken any disciplinary action against you?

Yes ☐ No ☐

16. Are you the subject of pending disciplinary actions by any licensing or certification board, government authority, hospital or health care facility or professional medical association located in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

17. Have you ever voluntarily surrendered any professional license or board certification in the United States or any country or foreign jurisdiction?

Yes ☐ No ☐

18. Have you ever been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor traffic violations for which a fine of $100 or less was imposed.

Yes ☐ No ☐ No Record ☐

RECOMMENDATIONS OF GOOD MORAL CHARACTER:

WE, THE UNDERSIGNED LICENSED DENTISTS, ARE PERSONALLY ACQUAINTED WITH THE APPLICANT NAMED IN THIS APPLICATION AND RECOMMEND HIM/HER AS A PERSON OF GOOD MORAL CHARACTER.

1. PRINTED NAME_____ STATE AND LICENSE NUMBER_____

   ADDRESS_____

   SIGNATURE _____

2. PRINTED NAME_____ STATE AND LICENSE NUMBER_____

   ADDRESS_____

   SIGNATURE _____

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Board of Registration in Dentistry
250 Washington Street, Boston, MA 02108

CHARLES D. BAKER
Governor
KARYN E. POLITO
Lieutenant Governor

Tel: 617-973-0971
Fax: 617-973-0980
www.mass.gov/dph/dentalboard

MARYLOU SUDDERS
Secretary
MARGRET R. COOKE
Commissioner

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

TO BE USED BY ORGANIZATIONS CONDUCTING CORI CHECKS FOR EMPLOYMENT, VOLUNTEER, SUBCONTRACTOR, LICENSING, AND HOUSING PURPOSES.

The Board of Registration in Dentistry is registered under the provisions of M.G.L. c. 6, § 172 to receive CORI for the purpose of screening current and otherwise qualified license applicants and current licensees. As a prospective or current license applicant or current licensee, I understand that a CORI check will be submitted for my personal information to the Department of Criminal Justice Information Systems (DCJIS). I hereby acknowledge and provide permission to the Board of Registration in Dentistry to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing written notice of my intent to withdraw consent to a CORI check.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

The Board of Registration in Dentistry may conduct subsequent CORI checks within one year of the date this Form was signed by me provided, however, that Board of Registration in Dentistry must first provide me with written notice of this check.

By signing below, I provide my consent to a CORI check and acknowledge that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

_____
SIGNATURE

_____
DATE

NOTE: The Board of Registration in Dentistry cannot accept this form unless it is either (1) signed in person at the Board's offices in the presence of a BHPL employee who has verified the applicant's identity through acceptable identification, or (2) signed in the presence of a notary public who has likewise verified identity and then mailed or hand-delivered to the Board's offices at the address set forth above.

CRIMINAL OFFENDER RECORD INFORMATION (CORI) ACKNOWLEDGEMENT FORM

SUBJECT INFORMATION: (An asterisk (*) denotes a required field)

_____

*Last Name *First Name Middle Name Suffix

_____

Maiden Name (or other name(s) by which you have been known)

_____ _____

Date of Birth Place of Birth

Last Six Digits of Your Social Security Number: _____-_____

Sex: ____ Height: ___ft. __ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

_____ _____

Mother's Full Name (Mother's Maiden Name) Father's Full Name

Current and Former Addresses:

_____

Street Number & Name City/Town State Zip

_____

Street Number & Name City/Town State Zip

_____

The identity of the subject of this acknowledgement form was verified by reviewing the following form(s) of government-issued identification:

_____

_____

VERIFIED BY: _____ ON _____

Name of Verifying BHPL Employee or Notary Public (Please Print) Date

_____

Signature of Verifying BHPL Employee or Notary Public

NOTARY NAME: _____

COMMISSION EXPIRES: _____ [Seal or stamp]

Enrollment with MassHealth as an ORP Non-Billing Provider

Effective November 3, 2017, each dentist must enroll with MassHealth as an Ordering, Referring and Prescribing ("ORP") non-billing provider (if not already enrolled with MassHealth as an approved, billing provider) before applying for an initial dental license or seeking to renew an existing dental license.

M.G.L. c. 112, s. 45 mandates that the Board of Registration in Dentistry ("Board") condition the issuance or renewal of dentist licensure on the dentist's application to participate in MassHealth as an ORP non-billing provider unless the dentist is already enrolled as a billing provider. Accordingly, your initial dental license will not be issued and you cannot renew an existing dental license until you submit an ORP application to MassHealth. As part of the initial licensure process and/or during the online licensure renewal process you will be asked to attest that you have submitted an ORP application.

To avoid delays in acquiring your initial dental license or in renewing your existing dental license, you are advised to complete your ORP non-billing provider enrollment with MassHealth at your earliest convenience.

For information on the ORP non-billing provider requirements and how to enroll with MassHealth, please refer to the link below:
https://www.mass.gov/masshealth-order-refer-and-prescribe-orp-provider
Or call the DentaQuest Credentialing Customer Service Center (MassHealth) at **1-800-233-1468**.

MASSHEALTH WILL SEND YOU AN EMAIL CONFIRMING RECEIPT OF YOUR APPLICATION.
YOU MUST ENCLOSE THAT EMAIL WITH YOUR LICENSE APPLICATION.

QUESTIONS TO BE ANSWERED BY EACH LICENSURE APPLICANT:
(PLEASE RETURN THIS COMPLETED PAGE WITH YOUR APPLICATION)

1. Are you enrolled in MassHealth as a fully participating provider or non-billing provider **OR** have you submitted a thoroughly completed application to be a fully participating provider or non-billing provider and a signed provider contract to MassHealth?

   ☐ YES ☐ NO

2. Do you consent to the Bureau of Health Professions Licensure and the Massachusetts Executive Office of Health and Human Services, and its enrollment vendor, to obtain, read, copy and share with each other information regarding your MassHealth application and enrollment status and professional licensure status?

   ☐ YES ☐ NO

RELEASE

I hereby authorize all hospitals, institutions, credentialing agencies, organizations, personal physicians, employers (past and present), business and dental associates (past and present), and all government agencies and entities (local, state, federal, or foreign) to release to the Massachusetts Board of Registration in Dentistry (Board) any information, files or records requested by the Board in connection with the processing of my application. I further authorize the Board to release information contained in this application in association with its processing.

AFFIDAVIT OF APPLICANT

To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by state law and do not owe child support. I am aware of my professional obligations under M.G.L. c. 119 s. 51A, regarding the reporting of suspected child abuse.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board for access to Criminal Offender Record Information (CORI), including conviction and pending criminal case data. As an applicant for a license to practice as a dentist I understand that a CORI check may be conducted by the Board for conviction and pending criminal case information only and that the CORI results will not necessarily disqualify me.

I understand that I am responsible for reading and understanding the laws and regulations governing my practice as a licensed dentist in Massachusetts and I hereby agree to comply with such laws and regulations.

I understand that this application for licensure as a dentist shall be deemed no longer valid if the requirements for licensure as a dentist are not met within one (1) year from the date the Board receives my application. I also understand that all licensure fees are non-refundable and non-transferable.

I hereby attest that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that any failure to provide truthful and accurate information in connection with this application for licensure may be grounds for the Board to deny the issuance of a license, to suspend or revoke a license issued to me, and to deny the renewal of a license issued to me, all in accordance with Massachusetts law.

To be completed, signed and witnessed by the applicant and Notary Public.

APPLICANT SIGNATURE _____ DATE _____

PRINT NAME _____

Attach a recent color photo (passport sized or larger)
NO STAPLES

NOTARY NAME: _____

COMMISSION EXPIRES: _____ [Seal or Stamp]

DO NOT FORGET TO INCLUDE A CHECK OR MONEY ORDER FOR THE NON-REFUNDABLE AND NON-TRANSFERABLE LICENSURE FEE OF $660 (PAYABLE TO THE COMMONWEALTH OF MASSACHUSETTS). DO NOT STAPLE THE PAYMENT TO THIS APPLICATION.

ATTACHMENT CHECKLIST

☐ **Attachment 1: Licensing Fee** – A personal check, business check or money order payable to the Commonwealth of Massachusetts in the amount of $660. All fees are non-refundable and non-transferable. Please do not staple your payment to the application.

☐ **Attachment 2: Proof of Graduation** – An original transcript with school seal indicating the degree awarded and date of graduation **or** an original, signed letter from the Dean's or Registrar's office indicating the degree awarded and date of graduation. Photocopies of transcripts are not acceptable.

☐ **Attachment 3: National Board Certification Part I and II** – Contact NBDE to have scores released to the Board via the NBDE secure portal. NBDE assesses a fee for this service.

☐ **Attachment 4: Proof of Regional or State Clinical Examination** - Proof of your successful completion of a Board-approved regional or state clinical competency examination must be included with the application. CDCA exam scores are sent directly to the Board therefore a copy of your CDCA exam scores is not necessary.

☐ **Attachment 5: Physician's Statement** – An examination and statement from your primary care provider, nurse practitioner or physician's assistant certifying that you are medically cleared to practice dentistry. The examination must be completed within the previous 12 months of your licensure application.

☐ **Attachment 6: Proof of your current certification in CPR/AED for the Professional Rescuer, Basic Life Support for Healthcare Providers (BLS) or ACLS/PALS is required.** Include a copy of both sides of your certification card with your application.

☐ **Attachment 7: Massachusetts Dental Ethics and Jurisprudence Exam** - Answer sheet only. You may keep the copy of the actual exam.

☐ **Attachment 8: Proof of the successful completion of a Board-approved continuing education course on safe and effective opioid prescribing/pain management.** Refer to the Board's website at www.mass.gov/dph/dentalboard for info on how to access Board-approved courses; click on the link for "Alerts" then "PMP & Mandatory Educational Requirements for Prescribers."

☐ **Attachment 9: Email confirming receipt of your application to MassHealth.**

IF APPLICABLE:

☐ **Attachment 10: Letters of Standing** – Official verification of professional licensure from each state or jurisdiction in which you now hold or ever have held a license must be included with your application. The letter of verification must include the current status of your license, your license number, the official seal and signature of the jurisdiction's licensing board and any disciplinary action taken. A photocopy of your out-of-state license is not acceptable.

☐ **Attachment 11: Practice History** - If you have ever practiced dentistry in another jurisdiction or state, please include a current copy of your resume, curriculum vitae or practice history.

☐ **Attachment 12: National Practitioner Data Bank Self-Query** - (Required if you have ever held a professional healthcare license elsewhere in the United States) To request a self-query report, please contact the Data Bank at 1-800-767-6732 or www.npdb-hipdb.hrsa.gov. The Data Bank will mail the report to you. Only an original report from NPDB will be accepted with your application.

☐ **Attachment 13: CORI Acknowledgement Form** – Required if any of the Good Moral Character questions are answered "Yes." (See pages 5-7 of this application.)